COORDINATION IN LONG-TERM CARE IN ALBERTA

by

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Introduction

During the last three years steps have been taken to coordinate the planning and delivery of long-term care services in Alberta; many people have been and are involved in the process. It has been a complicated process. In Alberta three provincial departments have responsibility for these services, and there is much emphasis on local autonomy in the planning and delivery of long-term care, with several local boards playing a major role.

We would like to share with you today:

- our definition of long-term care;
- an explanation of how services are planned, organized and delivered in Alberta;
- the reasons for the move toward coordination (problems in the system);
- the process, what has happened and what is happening now as well as who is involved;
- and what we are finding to date (good things and some difficulties),

and then we would like to hear from you. What are your reactions to this? Do you have any suggestions or concerns?

Definition of Long-Term Care

First, it is important to define long-term care. What do we mean when we talk about long-term care services? (I am sure there are a number of definitions, depending on the province in which one lives.) We are defining it as:

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[1] This paper is based on a presentation at the Canadian Association on Gerontology Annual educational meeting, Quebec City, November, 1986. It has been updated (as of February 1987).

- One or more services that are required on a sustained basis to enable individuals, whose functional capabilities are chronically impaired, to be maintained at their optimum levels of health and well-being.

- Long-term care services may also include rehabilitation services to restore individuals to their optimum levels in independent functioning.

- Long-term care services may be provided on a non-institutional basis to persons in their own homes or in lodges and include home care, day care and day hospital services. In this instance, they may include homemaking, personal care, home help, handyman services, counselling, transportation, home-delivered meals as well as professional nursing and rehabilitation services.

- Long-term care services may be provided within an institution, for example, in Alberta in a nursing home or auxiliary hospital (those of you from other provinces would have different names for these institutions). In this instance they include a range of the above services as well as shelter, food services and 24-hour supervision.

I should point out that any of these services can be provided on a short-term basis--perhaps continuing care is a better name than long-term care. Also I do want to emphasize that there are many other services that are very important for seniors - what I call "preventive" services as well as income support, subsidized housing, etc. I think they are most important, but we are not dealing with them in this specific effort in coordination. We are dealing with specialized services for people with special needs.

In Alberta the long-term care services included in the planning we are describing are home care, lodges, nursing homes and auxiliary hospitals. Adult day care or day programs and day hospitals are also included, but as yet Alberta has relatively few of these day services. The majority of the users of all these long-term care services are persons aged 65 and over, about 80 percent.

It is recognized that there are some additional home-delivered services funded through a provincial/municipal social service program, the Family and Community Support Services Program, but there is great variation in these services from community to community. Also, often home care coordinates with and uses these services--contracts with them.

The Present Situation

Now what led to the concern about long-term care services in Alberta and to these steps towards coordination? It helps to understand this if one looks at how services are presently organized, delivered and funded.

In our province, at least three provincial departments have responsibility for long-term care services, and each of these three departments relates to local boards with varying degrees of autonomy.

The Department of Community and Occupational Health is responsible for the home care program which includes both the health and support services mentioned earlier. It funds the 27 health units which then administer the program. In 1985, 85 percent of the users of home care (9,365 persons in March 1985) were seniors. Each health unit home care program must provide nursing and homemaker services. Beyond that there are local variations in the range of health and support services provided.

The Department of Municipal Affairs, through the Mortgage and Housing Corporation, builds lodges which are then turned over to municipal foundations (now 57 of them) to operate. We have 135 lodges (with 7,823 beds) which provide board and room, and as of July 1986 had a vacancy rate of 13 percent.

The Department of Hospitals and Medical Care is responsible for nursing homes and auxiliary hospitals. We should explain that nursing homes provide personal care under nursing supervision, and auxiliary hospitals provide skilled nursing and medical care to chronically ill/disabled persons. The Department funds, on a per diem basis, the nursing homes which are operated by local districts/boards (about 80 of them), voluntary organizations and private enterprise. It also funds auxiliary hospitals operated by district boards and

voluntary organizations. The district boards are responsible for assessment, for determining eligibility for this heavily subsidized care, and for determining needs for additional beds (in cooperation with the Department of Hospitals and Medical Care). We had, as of March 1986, 7,815 nursing home beds and 4,839 auxiliary hospitals beds.

Until the present developments, each of these provincial departments planned and developed services quite independently--at least at the bureaucratic level. If communication took place, it was done informally and on the basis of goodwill. The same practices take place at the local level among the local boards and service providers. Each of the long-term care services has its own assessment criteria and practices. As the boundaries of these service areas (27 health units, 57 foundations and 80 districts) are in no way coterminous this does not make cooperation easier, and it makes it very difficult to gather sense-making planning data!

Rationale/Reasons for Steps Toward Coordination

Concern developed about this state of affairs in the late 1970s and early 1980s. There was a major review of the Nursing Home Program by a special panel appointed by the Minister of Hospitals and Medical Care. The report of this panel (The Nursing Home Review Panel Report 1982) identified the need for a coordinated assessment and placement service for long-term care, a single point of entry. The need for this was also pointed out in "The Assessment and Placement Study for Long-Term Care (September 1982). This study showed the great variation in assessment practices and the duplication. An Alberta Symposium on Aging, held in 1982, also recommended a single point of entry to all these long-term care services - one contact point in each community/region, calling strongly for coordinated planning and delivery. The government-appointed Senior Citizens Advisory Council also made repeated recommendations to this effect.

Problems

What were/are some of the problems identified?

(1) Duplication of assessment practices--a person needing help may have to go to several different services and receive several different assessments. Within the same community there may be several groups of paid staff assessing for service eligibility. This is costly and confusing.

(2) People seeking help are assessed for service eligibility--do these people fit into our service?--rather than for need. What are their needs for help? Often only one service is considered, the service to which the person first goes. The decision for "placement" (where the person should receive service) is made and only then is the assessment done.

(3) Different assessment criteria and practices are used. There has been, and is, great variation, so there is much inconsistency in the way services are arranged for, and used, by people in need. The assessment process used often depends on the skills of one kind of professional, making it difficult to look effectively at the multiple health and social problems faced by some persons. We have incomplete and fragmented assessments.

(4) There is little case management or comprehensive planning with the person in need to ensure that appropriate help is found. If a person is not eligible for one service, s/he is not necessarily assisted to find the appropriate ones.

(5) Last of all, too often there is little involvement of the person seeking help in determining his or her needs, and little involvement of families. Decisions are made for people based on external factors, such as the need to get the person out of a hospital bed.

Now I must emphasize that of course there are situations where people receive very good and appropriate assessments and care/help, due to the fact that they have found someone who is a skilled and knowledgeable person with information, for example, doctor, nurse or social worker. But they are lucky. Seeking help was and still is very confusing for older people, their families and even service-providers! The service one first approaches is what one usually receives (or does not receive). The situation looks like a maze!

Interdepartmental Committee

So in view of the concerns being raised, the very specific recommendations made by the Nursing Home Review Panel, and the need more and more to make the best possible use of financial and human resources, the Government established the Interdepartmental Committee on Long-Term Care. It gave the Committee the responsibility to look at ways of coordinating long-term care and to develop recommendations.

Senior officials from four departments are on it: Hospitals and Medical Care, Community and Occupational Health, Social Services, and Municipal Affairs. (These were not the names of the departments and there were only three when the Committee was established.) The Secretariat for the Committee consists of the director of the Senior Citizens Secretariat and the Director of the Research and Strategic Planning Branch, Hospitals and Medical Care.[2]

The Committee agreed with the recommendations for one coordinated assessment and placement process within a region, feeling this would provide a focal point which would help all long-term care services work together, sharing their skills and expertise to help people. For the people in need of help, it would be a one-stop shopping approach to obtaining services.

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[2] A long-term care planner from the Department of Community and Occupational Health was added to the Secretariat of the Committee in January 1987.

The Model

The Committee felt that rather than developing a new system and "laying the system on" all the services, it would be best to develop a model and test it in one or two areas--work out the problems and get greater community input into this new approach in service delivery.

So a model was developed, and the paper describing it sent to a variety of service-providing organizations and consumer groups, including seniors' groups, asking for comments. Some of the groups involved were the Alberta Council on Aging, the Alberta Hospital Association, the Alberta Long-Term Care Association and the Health Unit Association of Alberta.

Well, we sure got comments! We didn't just get comments - we got a lot of flack! One of the comments which amazed us the most was that the model removed control from people seeking help. It didn't really--in fact it was trying to return control to people and remove it from some professionals--but we made sure to really build this concept even more strongly into the redraft. We also made a number of other changes in response to concerns. For example, another one was the proposed size of the model region. Every board felt its region was ideal size! Workshops were then held throughout the province, with representatives of all three (it was then 3) departments participating, and a paper describing the model, the rationale for it, its philosophy, principles and structure was distributed. The model, it should be explained, is in some ways a compromise--trying to retain some of the existing local structures and using them, at least for the pilot period. It is a way of linking the long-term care components together, rather than integrating them, and a way to do this within the existing legislative mandates of each department.

Principles of the Model

The emphasis in the model is on:

- determining the needs of the older person;
- providing the most appropriate care available in the community;

- keeping people in the community if possible;
- involving persons seeking help in determining their needs and in developing a plan of care; and
- involving families of the persons needing special care.

It was recognized that if people move into an institution before the need to do so, it creates much unnecessary dependency.

Procedures

Assessment: First a thorough assessment is made. Based upon this assessment, the plan of care and the placement decision is made. Assessment involves the collection of information about the applicant, with that person's cooperation and assistance, on:

- functioning abilities;
- psychosocial status;
- support system (formal and informal)
- environment
- medical health needs, and
- social needs.

Assessment looks at total needs.

Placement: This is not a final positioning of a person in a slot but involves identifying services needed, and determining where these services are to be offered (at home or in an institution).

Case Management: This becomes an important component and involves:

- assessing need;
- establishing a plan;
- implementing a plan;
- ensuring the plan is carried out, and
- ongoing reassessment.

This model emphasizes a case management approach, attempting to meet the needs of the older person involved in the most acceptable manner to the person possible, considering the resources of the community. It emphasizes flexibility on the part of the case manager. Ongoing reassessment is encouraged in order to relate to any changes that occur. Efforts are made to respond promptly to referrals or to the needs of the person involved.

Appeal process: the model has an independent appeal process for older persons, service providers, families or physicians.

The model provides a plan for "one-stop shopping." There is a single entry to long-term care whether it is delivered at home or at a nursing home, lodge or auxiliary hospital. Only one assessment is made.

Benefits

This one point of contact for the person in need means greater consistency in approach from one applicant to another. The possibility is greater that the person will not be lost in the referral process, and it ensures that the person will be assessed for need for service rather than for eligibility only.

Pilot Testing

This model was presented to regional groups in all areas of Alberta. Requests were made for proposals to test the model as a pilot project. Plans were that two models would be piloted--one urban and one rural. Proposals were judged primarily on the amount of community cooperation. It was assumed that the model would work better if all groups were interested in being a part of the proposed plan.

The decision was made that the proposal must represent a large enough region that there would be a variety of long-term care services available. Housing services, such as lodges, were not required to be a part of the proposal. As it turned out, lodges are a part of the rural project but not the urban one.

The two regions selected are both in Southern Alberta: Calgary for the urban area and the Foothills Health Unit area for the rural area. Both pilot projects follow the proposed model developed by the provincial committee. These pilots will operate for two years, and the results are being evaluated by Price Waterhouse.

The Foothills Health Unit area project began February 1986, and the Calgary area project began April 1986. Additional funding has been provided to them to implement the model and to hire the extra staff required. Each of the pilot sites has established a Regional Assessment and Placement Committee composed of service providers and consumers which is a part of the original model concept. This committee is overseeing the assessment/placement process during the pilot period.

All referrals for long-term care are being assessed by the staff of home care. Appropriate home care services are provided once the assessment is completed and needs are determined. If institutional care seems more appropriate, the individual is referred to the institutional case coordinator along with the assessment data in the rural area and with a recommendation as to type of institution (nursing home or auxiliary hospital).

In Calgary, the referral is to the former nursing home district placement staff (now institutional case coordinators). They use the assessment data to determine which facility is appropriate--nursing home, auxiliary hospital. In all instances the preferences of the applicant are considered.

Placement panels composed of professionals have been established to review placement decisions.

Assessment Tool

An important part of the pilot process has been the development of an assessment tool which can provide an accurate assessment of total needs. This has been very difficult.

The major functions of the tool are:

- to determine total needs;
- to determine the existing support systems;
- to determine where the needs can be met (in the home or in the institution).

The tool uses a check list to:

- describe the health status;
- determine functional status or ability to care for self or carry out the activities of daily living;
- describe the psychosocial status

The tool records help from family and friends and identifies other needs which must be met through formal services. A recommendation for placement (home care, nursing home, auxiliary hospital) is then made with consideration given to the preference of the person being assessed.

This assessment requires time--but a good assessment cannot be brief. When one is making a decision that may drastically affect a person's life, time is necessary to consider all aspects. Such decisions also affect public expenditures. Nursing home and auxiliary hospital care are expensive. The tool is being tested for reliability and validity. So far it appears to be reliable in that it can be used effectively by assessors with differing professional backgrounds.

The validity testing is just now starting. This will determine whether the tool will really guide the assessor to the correct service needs and placement decisions.

The tool is being used in both pilot projects. There has been much criticism of the tool, and changes are still being made; however, last reports from the pilot areas indicated the tool was bringing positive results.

The Assessment and Placement Pilot Project Committee (Steering Committee)

This is a provincial committee reporting to the Interdepartmental Committee and composed of representatives from the Departments of Hospitals and Medical Care and Community and Occupational Health, the Alberta Mortgage and Housing Corporation, and the Senior Citizens Secretariat as well as non-government bodies such as the Health Unit Association of Alberta, the Alberta Hospital Association, and the Alberta Long-Term Care Association (private nursing homes). Representatives from the pilot areas are on the Committee.

The Regional Committees from the two pilot projects relate to this Committee. This Committee oversees the pilots, works on problems that develop and directs the evaluation. At the end of the pilot period it will make recommendations concerning further implementation of the model. This Committee meets monthly to receive reports from the pilot projects. It has been an important forum for discussing and resolving differences.

Evaluation of the Pilot Projects

The evaluation of the model will consist of:

- comparing the performance of the assessment/placement arrangements before and after implementing the model;
- an analysis of the degree to which the model has been implemented as planned;
- the identification of constraints;
- a limited and qualified cost analysis and benefit review.

There will be interviews of service providers, collection of agency data and surveys of clients.

What are the Concerns Being Raised in Relation to the Pilot Testing of the Model?

1) Some professionals fear that the model will result in increased waiting time for people needing help, but this has not resulted as yet.

2) Some fear it will result in much more paper work.

3) There have been conflicts in determining each person's role, particularly in the urban model.

4) Work loads for home care staff have increased though additional funds have been allotted to handle this problem.

5) Decision regarding the participation of lodges is still undecided--whether they should be regarded as housing with care provided or just housing.

6) Setting up the committees, organizing and getting the project under way has been time consuming.

7) It is not clear that we have achieved an overall system approach with case management. This approach has varied from one pilot area to the other.

8) The authority of the Regional Committee needs to be clarified.

What are some of the initial results?

1) Indications are that people who would previously have gone into institutional care are now being maintained at home.

2) A trend is developing toward more appropriate utilization of nursing home and auxiliary hospital beds; for example, in the Foothills area about 40 persons have been discharged from institutions and are now living in a more independent situations.

3) The use of the assessment tool and the review by the placement panel seem to be helpful in helping to ensure that older (and younger) persons receive appropriate help.

4) The Regional Committee is beginning to identify gaps in services because one of the requirements of the assessment tool is an explanation of those situations where the actual placement is different than the recommended placement; this helps to identify any missing services which are needed to assure that people receive appropriate care.

Concluding Comments

Change is always difficult for all of us. It is more difficult for some than others. The model certainly involves change for many people. It involves:

- giving up some functions and a loss of power;
- taking on functions not previously performed;
- trying to clarify new roles and functions.

In general the consumers (individuals and seniors' organizations) have supported the concept of the model.

We feel we are working toward a more efficient, effective system. There have been many issues and dissensions and some disappointments in working with both the model and the tool. It would have been easier to set up a new system without all of the community and agency input but, in the long run, this way should develop a relevant practical system that will provide better service to the consumer and that will be acceptable to the service providers as well.

Considering the growing number of older people, particularly the group age 80 and over, it will allow us to make better use of our resources without decreasing the quality of the service offered.

We have learned that the Interprovincial Committee on Long-Term Care (Canada) is now recommending the concept of a single point of entry for all provinces. Possibly our experience in Alberta will help those provinces who have not yet achieved this to:

- relate services to the individual's needs and choices;
- use the most cost-effective and efficient services based on individual need and choice; and
- emphasize the use of community-based services whenever possible.

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